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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2718

CERTIFICATE OF DEATH

02706

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>HARFORD</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
24 TOWN <i>Harre de Grace</i>		4 hr 30 min		TOWN <i>North East</i>		07X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
71 <i>HARFORD Memorial Hosp</i>				<i>General Delivery</i>			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
<i>Baby</i>		<i>MARSHA</i>		<i>ARIZMENDI</i>		<i>MARCH 8 19 55</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>Colored</i>	<i>Newborn</i>	<i>March 8-1950</i>	<i>7</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<i>Harre de Grace, Md.</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Ruben G. Arizmendi</i>				<i>Velora G. WANZER</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
7620 IMMEDIATE CAUSE (A) <i>Atelectasis</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to <i>March 8</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>March 8</i> , 19 <i>55</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>George J. Stansbury</i>				ADDRESS (Street, city, town, state) <i>M.D. 569 Revolution St. Harre de Grace Md.</i>		DATE SIGNED <i>3/8/55</i>	
23. CAUSE CREMATION, MENT (SPECIFY)		DATE THEREOF <i>9 March 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Harford Memorial Hospital</i>		LOCATION (City, town, or county) (State) <i>Harre de Grace Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>Mar. 15-1955</i>		<i>A. L. Lewis M.D.</i>		<i>Harry R. Kelly Administrator</i>			

2035275406

CERTIFICATE OF DEATH

1955

Register No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF DECEASED

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF CLERK

12. SIGNATURE OF JUDGE

13. SIGNATURE OF SHERIFF

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF COURT

17. SIGNATURE OF STATE

18. SIGNATURE OF COUNTY

19. SIGNATURE OF CITY

20. SIGNATURE OF TOWN

BUREAU V. S.

MAR 16 1955

RECEIVED

MINNEAPOLIS, MN

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. PLACE OF DEATH
6. CAUSE OF DEATH
7. MANNER OF DEATH
8. SIGNATURE OF DECEASED
9. SIGNATURE OF WITNESSES
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF CLERK
12. SIGNATURE OF JUDGE
13. SIGNATURE OF SHERIFF
14. SIGNATURE OF CORONER
15. SIGNATURE OF JURY
16. SIGNATURE OF COURT
17. SIGNATURE OF STATE
18. SIGNATURE OF COUNTY
19. SIGNATURE OF CITY
20. SIGNATURE OF TOWN

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02707

2719

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>24 HAURE de Grace</u>		LENGTH OF STAY (in this place) <u>2 hrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun 07X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Dickie Allen Brooks</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 15 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>MAR. 15 '55</u>	9. AGE last birthday <u>-</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NO</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Harley Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Jewel Dean Key</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>If no</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>father - Wm Brooks</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>773.5 Respiratory failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Extreme prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from, 19....., to....., 19....., that I last saw the deceased alive on <u>15 March 1955</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>B. Bennett MD</u>				ADDRESS (Street, city, town, state) <u>Hauare de Grace Md</u>		DATE SIGNED <u>3-15-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Brooks</u>		LOCATION (City, town, or county) (State) <u>Nanysville N.C.</u>	
24. REC'D BY REGISTRAR DATE <u>Mar 16 - 1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>David Tran</u>		ADDRESS	

2135213990

MAR 13 1955



TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS A15C 1-55 10M

2720

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02708

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Haure de Grace</u>		<u>4 hrs</u>		TOWN <u>Rising Sun</u>		<u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Harford Memorial Hospital</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Vickie Lynn Brooks</u>				<u>March 15 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>F</u>	<u>W</u>		<u>15 March 1955</u>				<u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Newborn</u>		<u>no</u>		<u>md</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Harley Brooks</u>				<u>Jewell Dean Key</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>Father Wm. Brooks</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Respiratory failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Extreme prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>UNDERLYING CAUSE LAST</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... M., from the causes and on the date stated above.							
SIGNATURE <u>B. Norment</u>				ADDRESS <u>Haure de Grace Md</u>		DATE SIGNED <u>3-15-55</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/19/55</u>		<u>Brooks</u>		<u>Womensville N.C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Mar 16-1955</u>		<u>A. L. Lewis m.d.</u>		<u>William H. Davis</u>		<u>David Davis</u>	

2135212990.

CERTIFICATE OF DEATH

2780

BUREAU A. B.

MAR 18 1955

RECEIVED

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. MARRIAGE PLACE		9. OCCUPATION		10. CAUSE OF DEATH		11. PLACE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	

2736

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Aberdeen Rural</u>		8 mos.,		TOWN <u>Aberdeen, Rural,</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>John</u> (Middle) <u>Harris</u> (Last) <u>Butschky</u>				Mar. 6, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	widowed	Aug. 22, 1884	70 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Stationary Fireman		Shoe Factory		Balto., Co., Md.,		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Henry Butschky				Louisa Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(Yes, no, or unk.)		218-12-2276 A		Mrs. Anna Mc Fadden, Aberdeen, R.D. Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>ACUTE LEFT VENTRICULAR FAILURE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>ABOUT</u>			
ANTECEDENT CAUSE(S) DUE TO				2 YEARS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				ARTERIOSCLEROTIC HEART DISEASE WITH			
(B) <u>AURICULAR FIBRILLATION</u>				DUE TO			
(C) <u>GENERALIZED SEVERE ARTERIOSCLEROSIS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>GANGRENE OF RT. FOOT (DRY)</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/4</u> , 19 <u>55</u> , to <u>3/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/4</u> , 19 <u>55</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above. SIGNATURE <u>B. Stewart Jr.</u> M.D. ADDRESS <u>Box 95, Edgewood, Md</u> DATE/SIGNED <u>3/6/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Mar. 5, 1955		Moreland Memorial Park		Baltimore, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Mar. 9, 1955</u>		<u>Mollie Q. Perry</u>		<u>Howard K. Mc Comas & Son, Abingdon, Md.,</u>		<u>Howard K. Mc Comas Jr</u>	

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1955

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

BUREAU V. S.

MAR 10 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS A13C 1-55 10M

2721

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02710

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAURE DE GRACE</u>		<u>2 DAYS</u>		TOWN <u>HAURE DE GRACE</u>		<u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>71 HARFORD Memorial Hosp.</u>				<u>STAR ROUTE</u>		<u>1</u>	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Alfred ALLEN Colburn</u>				<u>MARCH 31, 1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
<u>MALE</u>		<u>WHITE</u>		<u>MARRIED</u>		<u>JULY 9, 1874</u>	
						<u>80</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>NIGHT CLERK</u>		<u>HOTEL</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edward Colburn</u>				<u>MARY Brooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>212-32-4360</u>		<u>Mrs. AVARILLA BALL COLBURN</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>177x</u> IMMEDIATE CAUSE (A) <u>Carcinoma of Lungs</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma Beginning in</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Prostate</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-17</u>, 19<u>54</u>, to <u>3-31</u>, 19<u>55</u>, that I last saw the deceased alive on <u>3/31</u>, 19<u>55</u>, and that death occurred at <u>6:25</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>A. L. Lewis M.D.</u>				ADDRESS (Street, city, town, state) <u>Haure de Grace Md. 4-2-55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>APRIL 3 '55</u>		<u>TRINITY CHURCH Y.P.</u>		<u>HARFORD MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>APR 2 - 55</u>		<u>A. L. Lewis M.D.</u>		<u>R. Madison Mitchell</u>		<u>HAURE DE GRACE MD.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTERS		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF BURIAL	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

RECEIVED
APR 4 1955
BUREAU V. S.

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APR 4 1955
BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2737

CERTIFICATE OF DEATH

02711

Reg. Dist. No. 182

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL OR TOWN) <u>RURAL-BELAIR</u>		LENGTH OF STAY (in this place) <u>6 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WHITEFORD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>BRYAN</u> (First) (Middle) (Last) <u>DONNAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAR. 9, 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>FEB 22, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JAMES DONNAN</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH LANE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>PAULINE COOPER, DELTA, PA.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
433.1 IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>						<u>UNK.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>AURICULAR FIBRILLATION AND ARTERIO-SCLEROSIS.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. el work el work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MARCH 5, 1955</u> , to <u>MARCH 9, 1955</u> , that I last saw the deceased alive on <u>7 MARCH, 1955</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Neuman</u>				ADDRESS (Street, city, town, state) <u>M.D. 307 HICKORY BEL AIR MD</u>		DATE SIGNED <u>10 MARCH 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>3-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>MT. NEBO</u>		LOCATION (City, town, or county) (State) <u>DELTA PA.</u>	
24. REC'D BY REGISTRAR <u>3-11-56</u>		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Haskins</u>		ADDRESS <u>Delta, Pa.</u>	

CERTIFICATE OF DEATH

Form No. 100

1. Usual Residence (Name of Decedent)

2. Date of Birth

3. Cause of Death

4. Place of Death

5. Date of Death

6. Signature of Physician

7. Signature of Registrar

8. Signature of Coroner

9. Signature of Medical Examiner

10. Signature of Burial Officer

11. Signature of Undertaker

12. Signature of Funeral Home

13. Signature of Cemetery

14. Signature of Burial Society

15. Signature of Burial Association

16. Signature of Burial Club

17. Signature of Burial League

18. Signature of Burial Order

19. Signature of Burial Certificate

20. Signature of Burial Record

21. Signature of Burial Index

22. Signature of Burial Book

23. Signature of Burial Card

24. Signature of Burial Ticket

BUREAU V. S.

MAR 16 1955

RECEIVED

Reg. Dist. No. 185-

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Harford	Maryland	STATE Maryland	COUNTY Harford
CITY (If outside corporate limits, write RURAL OR and give nearest town) Havre de Grace	LENGTH OF STAY (in this place) Lifetime	CITY (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Memorial	STREET ADDRESS (If rural give location) 815 Erie		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last) Rose B. Faltynowicz		(Month) (Day) (Year) 3/17/55	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 4/12/1919
9. AGE last birthday 35 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Havre de Grace
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Nick Benardi		14. MOTHER'S MAIDEN NAME Rachael Marrello	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Mrs. Rachael Benardi, 815 Erie			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
434.2 IMMEDIATE CAUSE (A) Cardiac Asthma			
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Embolus			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. Not while et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Mar 10, 1955 to Mar 17, 1955 ; that I last saw the deceased alive on Mar 17, 1955 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.			
SIGNATURE Charles J. Foley		DATE SIGNED 3/21/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR Mar 21-55	
DATE OF BURIAL 3/21/55		NAME OF CEMETERY OR CREMATORY Mt. Erin	
LOCATION (City, town, or county) (State) Havre de Grace, Md.		25. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son	
ADDRESS 400 D. Mum		ADDRESS Pennington & Son, Havre de Grace, Md.	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of medical examiner		14. Signature of coroner		15. Signature of jury	
16. Signature of health officer		17. Signature of local health officer		18. Signature of local health officer	
19. Signature of local health officer		20. Signature of local health officer		21. Signature of local health officer	
22. Signature of local health officer		23. Signature of local health officer		24. Signature of local health officer	
25. Signature of local health officer		26. Signature of local health officer		27. Signature of local health officer	
28. Signature of local health officer		29. Signature of local health officer		30. Signature of local health officer	
31. Signature of local health officer		32. Signature of local health officer		33. Signature of local health officer	
34. Signature of local health officer		35. Signature of local health officer		36. Signature of local health officer	
37. Signature of local health officer		38. Signature of local health officer		39. Signature of local health officer	
40. Signature of local health officer		41. Signature of local health officer		42. Signature of local health officer	
43. Signature of local health officer		44. Signature of local health officer		45. Signature of local health officer	
46. Signature of local health officer		47. Signature of local health officer		48. Signature of local health officer	
49. Signature of local health officer		50. Signature of local health officer		51. Signature of local health officer	
52. Signature of local health officer		53. Signature of local health officer		54. Signature of local health officer	
55. Signature of local health officer		56. Signature of local health officer		57. Signature of local health officer	
58. Signature of local health officer		59. Signature of local health officer		60. Signature of local health officer	
61. Signature of local health officer		62. Signature of local health officer		63. Signature of local health officer	
64. Signature of local health officer		65. Signature of local health officer		66. Signature of local health officer	
67. Signature of local health officer		68. Signature of local health officer		69. Signature of local health officer	
70. Signature of local health officer		71. Signature of local health officer		72. Signature of local health officer	
73. Signature of local health officer		74. Signature of local health officer		75. Signature of local health officer	
76. Signature of local health officer		77. Signature of local health officer		78. Signature of local health officer	
79. Signature of local health officer		80. Signature of local health officer		81. Signature of local health officer	
82. Signature of local health officer		83. Signature of local health officer		84. Signature of local health officer	
85. Signature of local health officer		86. Signature of local health officer		87. Signature of local health officer	
88. Signature of local health officer		89. Signature of local health officer		90. Signature of local health officer	
91. Signature of local health officer		92. Signature of local health officer		93. Signature of local health officer	
94. Signature of local health officer		95. Signature of local health officer		96. Signature of local health officer	
97. Signature of local health officer		98. Signature of local health officer		99. Signature of local health officer	
100. Signature of local health officer		101. Signature of local health officer		102. Signature of local health officer	

BUREAU V. S.

MAR 20 1917

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

2723

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02713

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
24 TOWN <u>HAURE DE GRACE</u>		2 Hrs 43 min.		24 TOWN <u>HAURE DE GRACE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
71 <u>HARFORD MEMORIAL HOSP.</u>				148 <u>BLOOMSBURY AVE.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)				FEARS			
5. SEX		6. COLOR OR RACE		8. DATE OF BIRTH		9. AGE last birthday	
MALE		WHITE				IF UNDER 1 YEAR IF UNDER 24 HRS.	
		3				Months Days Hours Min.	
						2 43	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
IRWIN FEARS				ELEANOR ELAINE FADLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
9							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
759.3 IMMEDIATE CAUSE (A) <u>RESPIRATORY FAILURE</u>							
ANTECEDENT CAUSE(S) DUE TO <u>CONGENITAL MAL DEVELOPMENT</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>MAL DEVELOPMENT OF PLACENTA</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. el work el work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>24 March, 1955</u> , to <u>24 March, 1955</u> , that I last saw the deceased alive on <u>24 March 1955</u> , and that death occurred at <u>11:40</u> p.m., from the causes and on the date stated above.							
SIGNATURE <u>RB Norman</u>				ADDRESS (Street, city, town, state) <u>602 S Union Ave Harwood Grace Md</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		3/25/52		Harford Memorial Hospital		Harwood Grace Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Mar. 27-1955</u>		<u>A. L. Lewis M. D.</u>		<u>Harry R. Kelly Administrator</u>			

2035263392

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2738

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 02714
 Reg. Dist.

No. 182

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Wilma</u>		LENGTH OF STAY (in this place) <u>3 years</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Wilma</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Thomas</u> (Middle) <u>Edward</u> (Last) <u>Fisher</u>				(Month) <u>March</u> (Day) <u>29</u> (Year) <u>1935</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 23, 1881</u>	9. AGE last birthday: <u>73</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farmer</u>		11. BIRTHPLACE (State or foreign country): <u>Harford Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Joseph Fisher</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ellen (Fisher)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY No.: <u>✓</u>		17. INFORMANT & ADDRESS: <u>John Fisher 136 N. Bond, Bel Air, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause (a) <u>Arteriosclerotic CV disease</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause</u> stating underlying cause last (c) <u>DUE TO</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Dorothy C. Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3/29/35</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Mar 31/35</u>		NAME OF CEMETERY OR CREMATORY: <u>Tabernacle Methodist</u>		LOCATION (City, town, or county) (State): <u>Benson Harford Md</u>	
DATE REC'D BY LOCAL REG. <u>3-30-35</u>		REGISTRAR'S SIGNATURE: <u>Priscilla Lowwood</u>		24. FUNERAL DIRECTOR: <u>Joseph T. Foster Bel Air Md</u>			

RECEIVED

APR 5 1955

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02715

2739

CERTIFICATE OF DEATH

Reg. Dist. No. 181

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Virginia</i> COUNTY <i>Culpeper</i>			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Churchville</i>		<i>at years</i>		TOWN <i>Culpeper</i>		<i>83X.3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Churchville - Public Road</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <i>Bessie</i>		(Middle) <i>Buckner</i>		(Last) <i>Fitzhugh</i>		<i>Mar 3 1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Nov - 29th 1877</i>	9. AGE last birthday <i>77</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jessie H. Garth</i>				14. MOTHER'S MAIDEN NAME <i>Linda Wayland</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>420</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>H 208 President St. O. Garth Fitzhugh Kensington Md.</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
174X IMMEDIATE CAUSE (A) <i>METASTATIC ADENOCARCINOMA</i>				<i>6 MONTHS</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>ADENOCARCINOMA, UTERUS</i>				<i>2 YEARS</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>(260X)</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>DIABETES MELLITUS</i>				<i>2 YEARS</i>			
19a. DATE OF OPERATION <i>2</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. el work el work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>JAN 1 1953</i> , to <i>MARCH 3 1953</i> , that I last saw the deceased alive on <i>MARCH 2 1953</i> , and that death occurred at <i>4:20 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Brown McDonald</i>		ADDRESS (Street, city, town, state) <i>100 PARKE ST. ABERDEEN, MD.</i>		DATE SIGNED <i>3-3-53</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		DATE THEREOF <i>3/4/55</i>		NAME OF CEMETERY OR CREMATORY <i>Signum Cemetery</i>		LOCATION (City, town, or county) (State) <i>Signum Virginia</i>	
24. REC'D BY REGISTRAR <i>Mar 4 - 55</i>		REGISTRAR'S SIGNATURE <i>Mellie G. Perry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Tarrance</i>		ADDRESS <i>aberdien md.</i>	

CERTIFICATE OF DEATH

2338

REG. DIST. NO.

1. USUAL RESIDENCE (HOMER OF OCCUPANT)

2. PLACE OF DEATH

MARRIAGE

DATE

3. NAME OF DECEASED

4. DATE OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

BUREAU K. 1
1965

RECEIVED
JAN 8 1965

SIGNATURE

DATE

7. PLACE OF BIRTH

8. PLACE OF DEATH

NOTED

RECEIVED JAN 8 1965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

2740

02716

1. PLACE OF DEATH: COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
TOWN <u>Joppa</u>		TOWN <u>Joppa</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MAGNOLIA ROAD</u>		STREET ADDRESS (If rural, give location) <u>MAGNOLIA ROAD</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARION</u> <u>G.</u> <u>FLEETWOOD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MAR.</u> <u>31</u> <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-26-1869</u>
9. AGE last birthday <u>85</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM C. BISCOE</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>MRS. ADA L. CROUSE - Joppa - MD.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebrovascular accidentAntecedent cause(s) (b) Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3-27, 1955, to 3-31, 1955, that I last saw the deceased alive on 3-28, 1955, and that death occurred at 520 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 2, 1955R.W.G. HOWARD STRONG 3207 W. NORTH AVE.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2741

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 02717
 Reg. Dist.

No. 181

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CECIL</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN ADERISFEN PROVING GROUNDS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR <u>TOWN ELKTON RD 3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				STREET ADDRESS (If rural, give location) <u>07X-24</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles Benjamin</u> (Middle) <u>Franklin</u> (Last) <u>Franklin</u>				(Month) <u>March</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>MAY 5 1915</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Metal Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Salvage</u>		9. AGE last birthday: <u>39</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>CHARLES FRANKLIN</u>			
14. MOTHER'S MAIDEN NAME: <u>ESTHER REYNOLDS</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY No.: <u>216-05-6086</u>				17. INFORMANT & ADDRESS: <u>Margaret Franklin Elkton RD 3 Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Crushing Injury Chest</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						—	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>APR</u>		21c. (City or town) <u>Hardeana</u> (County) <u>Harford</u> (State) <u>MD</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3/26/55 10 A M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>An plane landing gear fell on him</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Lerald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3/26/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> M. D.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>March 27-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Methodist</u>		LOCATION (City, town, or county) (State) <u>Elkton RD Cecil, Md</u>	
DATE REC'D BY LOCAL REG. <u>March 30-55</u>		REGISTRAR'S SIGNATURE <u>Nellie C Perry</u>		24. FUNERAL DIRECTOR <u>Joseph R Grant North East, Md</u>		ADDRESS	

RECEIVED

APR 1 1955

BUREAU V. S.

2724

02718

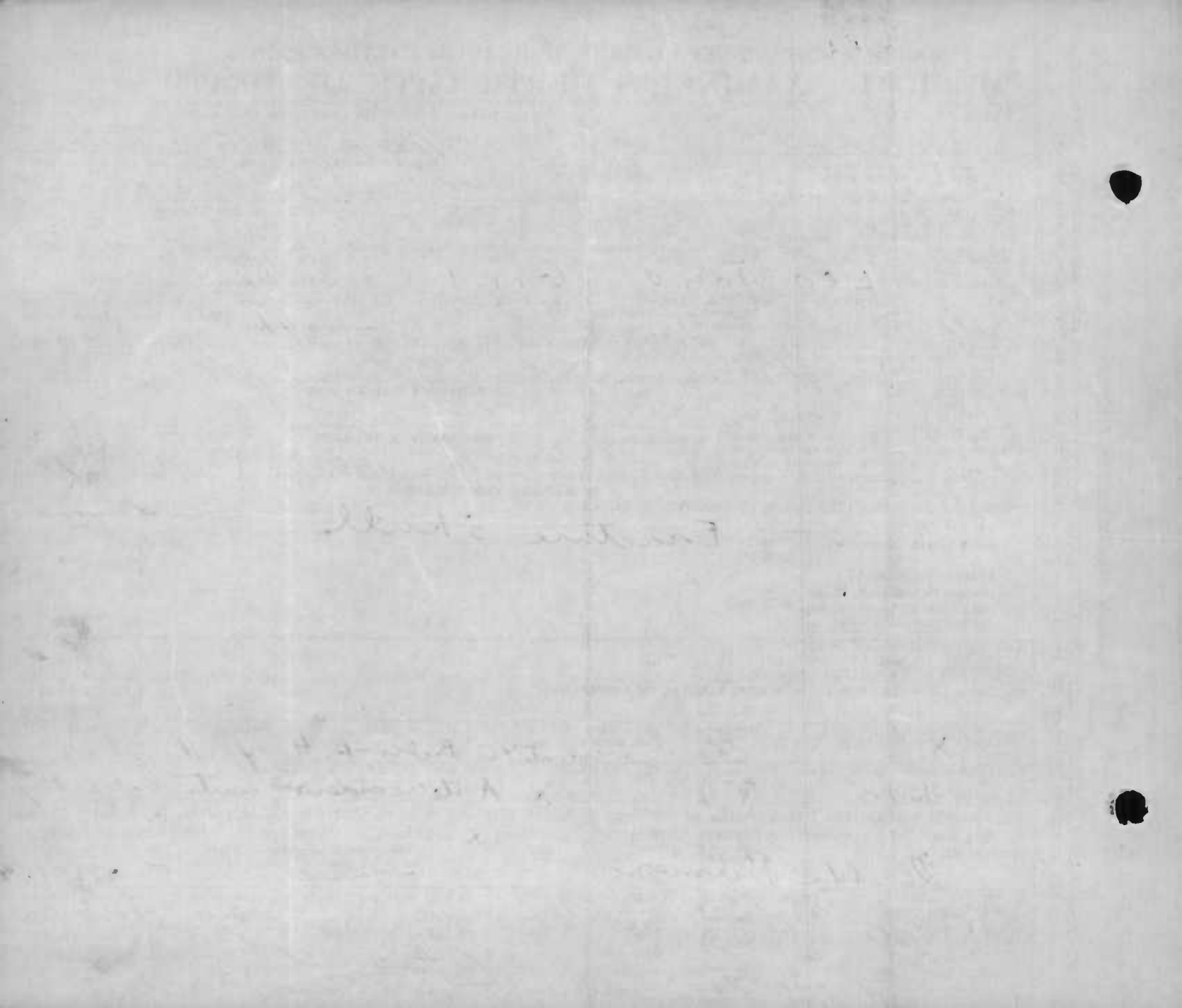
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Brooklyn Heights (Baltimore)</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Brooklyn Heights (Baltimore)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Hospital</u>		STREET ADDRESS (If rural, give location) <u>5209 Patrick Henry Drive</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>Leo John</u> (Middle) <u>Grail</u> (Last)		(Month) <u>March</u> (Day) <u>20</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 6, 1908</u>
9. AGE last birthday: <u>46</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Mins. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Lab Maintenance - Taxi Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Baltimore, Md</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Thomas J. Grail</u>		14. MOTHER'S MAIDEN NAME: <u>Mary (?)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>217-05-7534</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mrs. Mildred J. Grail (Same)</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Fracture skull</u> Antecedent cause(s) (b) <u>819X</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Due to</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>3/20/55</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>ns Rm 10 Belcamp Harford Md</u>	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3/20/55</u> <u>P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>Auto accident - auto - object type</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Mildred C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3/20/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Normal</u>		DATE THEREOF <u>March 23-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem - Brooklyn, A.G.C. Md</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>3/20/55</u>		REGISTERAR'S SIGNATURE <u>J. Howard Evans</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>1400 S Charles St Baltimore 30 Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

2725 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02719

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAVRE DE GRACE</u>		<u>25 YRS.</u>		TOWN <u>HAVRE DE GRACE</u>		<u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>71 525 N. STOKES, ST.</u>				<u>525 N. STOKES, ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>WILLIAM ROBERT GRIMSEY</u>				<u>MAR. 22,</u>		<u>1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>FEB. 24, 1894</u>	<u>61</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>FOREMAN MAINTENANCE OF WAX PLANT</u>				<u>PENN.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM HENRY GRIMSEY</u>				<u>ELIZABETH TRIMBLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>1 -</u>		<u>717-07-5476</u>		<u>MRS. ETHEL D. GRIMSEY</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A)				<u>Chronic Myocarditis & decompensation</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>none</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
				<u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-13</u> , 19 <u>55</u> , to <u>3-22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-22</u> , 19 <u>55</u> , and that death occurred at <u>9 P.</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Joseph R. Polce</u>				<u>Havre de Grace, Md.</u>		<u>3-23-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>MAR 25 1955</u>		<u>ANGEL HILL</u>		<u>HAVRE DE GRACE, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Mar. 25-1955</u>		<u>A. L. Lewis</u>		<u>F. Madison Mitchell</u>		<u>HAVRE DE GRACE, MD.</u>	



RE

MAR 28 1965

2726

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. 34.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 185

1. PLACE OF DEATH:

CITY (If outside corporate limits, write RURAL OR and give nearest town) *Harford* STATE *Maryland* MARYLAND
 TOWN *Harde Chase* LENGTH OF STAY (in this place) *10 yrs.*
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

CITY (If outside corporate limits write RURAL and give nearest town) *Harford* STATE *Maryland* COUNTY *Harford*
 TOWN *Harde Chase* 24-
 STREET ADDRESS (If rural, give location) *Euclid St.* 1

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

*James**Harris*

4. DATE OF DEATH

(Month)

(Day)

(Year)

*March**1**19**55*

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED:

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

*Male**Negro**Widowed**Unknown**abt. 70**yrs.**Months**Days**Hours**Min.*

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

*Monitor**Boys Apts.**Unknown**U.S.A.*

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

*Unknown**Unknown*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT & ADDRESS:

*Unknown**932-18-3279**Welfau Road, Bel Air, Md.*

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

*422.1**Immediate cause**(a) Atherosclerotic CV disease**DUE TO**Antecedent cause(s)**(b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last**(c)*

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ *No* ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Gerald C Palmer

CHIEF MEDICAL EXAMINER ☐
 DEPUTY MEDICAL EXAMINER ☒
 ASSISTANT MEDICAL EXAM ☐

DATE SIGNED

M. D.

3/2/55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*Mar. 4-55**A. J. Lewis M.D.**Funeral Home**Harde Chase, Md.*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 7 1955

RECEIVED

2727

02721

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 180-

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Harford</i> MARYLAND		CITY (If outside corporate limits write RURAL OR and give nearest town) <i>Beltsville</i>		STATE <i>Maryland</i> COUNTY <i>Harford</i>		CITY (If outside corporate limits write RURAL and give nearest town) <i>Beltsville</i>	
TOWN <i>Beltsville</i>		LENGTH OF STAY (in this place) <i>2m</i>		TOWN <i>Beltsville</i>		STREET ADDRESS (If rural, give location) <i>1805 Federal Ave.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Mem.</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>March 2 1955</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Charles A. Hoffman</i>				5. AGE last birthday: <i>27</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
5. SEX: <i>M.</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>Single</i>		8. DATE OF BIRTH: <i>Dec 9 1927</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Bookkeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>City of Harford</i>		11. BIRTHPLACE (State or foreign country): <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY: <i>USA</i>	
13. FATHER'S NAME: <i>Charles A. Hoffman</i>				14. MOTHER'S MAIDEN NAME: <i>Grace Peacock</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>9</i>		16. SOCIAL SECURITY No.: <i>2217 Christian St</i>		17. INFORMANT & ADDRESS: <i>Mary W. Full Baltimore Md</i>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
812X Immediate cause (a) <i>Fracture skull</i> DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
CAUSE OF DEATH (c) stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <i>Fracture pelvis</i>							
19a. DATE OF OPERATION: <i>0</i>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>25 Kent 40</i>		21c. (City or town) (County) (State) <i>Beltsville Harford Md</i>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>March 2, 1955 2 A.M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Auto accident anteroposterior type</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Derald C Palmer</i>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>3/2/55</i>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Beltsville</i>		DATE THEREOF <i>3/5/55</i>		NAME OF CEMETERY OR CREMATORY <i>Beltsville Md. Mt. View</i>		LOCATION (City, town, or county) (State) <i>Beltsville Md.</i>	
DATE REC'D BY LOCAL REG. <i>Mar 2-55</i>		REGISTRAR'S SIGNATURE <i>A. L. Lewis m.d.</i>		24. FUNERAL DIRECTOR <i>Harry H. Witzke</i>		ADDRESS <i>4107 Edmonson Ave</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED

MAR 7 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2728

CERTIFICATE OF DEATH

02722

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAURE DE GRACE</u>		LENGTH OF STAY (in this place) <u>31 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ABERDEEN</u>		<u>31</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location) <u>BUSH CHAPEL ROAD</u>		<u>1</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Thomas H Hollingsworth</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 30 1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7-3-1867</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>W^m Henry Hollingsworth</u>				14. MOTHER'S MAIDEN NAME <u>Lisa Lisby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY NO. <u>(If Yes, give war or deces of service)</u>		17. INFORMANT & ADDRESS <u>Mrs. Hattie Christy - Perryman, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
177X IMMEDIATE CAUSE (A) <u>Carcinoma of Prostate</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Azotemia with Cardiac Failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerotic Heart disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/27</u> , 19 <u>55</u> , to <u>3/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>55</u> , and that death occurred at <u>10:00</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city, town, state) <u>569 Revolution St. Harre de Grace, Md.</u>		DATE SIGNED <u>3/31/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cemetery</u>		LOCATION (City, town, or county) (State) <u>W. Aberdeen, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Apr. 1 - 1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M. d.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock</u>		ADDRESS <u>Harre de Grace</u>	

md

CERTIFICATE OF DEATH

1965

1965

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. MARRIAGE DATE

8. OCCUPATION

9. CAUSE OF DEATH

10. PLACE OF DEATH

11. TIME OF DEATH

12. SIGNATURE

13. DATE

14. SIGNATURE

15. DATE

16. SIGNATURE

17. DATE

18. SIGNATURE

19. DATE

20. SIGNATURE

21. DATE

22. SIGNATURE

23. DATE

24. SIGNATURE

25. DATE

26. SIGNATURE

27. DATE

28. SIGNATURE

29. DATE

30. SIGNATURE

31. DATE

32. SIGNATURE

33. DATE

BUREAU V. S.

1965

APR 4

RECEIVED

PHOTOGRAPH

1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. BIRTH DATE
6. BIRTH PLACE
7. MARRIAGE DATE
8. OCCUPATION
9. CAUSE OF DEATH
10. PLACE OF DEATH
11. TIME OF DEATH
12. SIGNATURE
13. DATE
14. SIGNATURE
15. DATE
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27. DATE
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31. DATE
32. SIGNATURE
33. DATE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

2729

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02723

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>24 HAVRE DE GRACE</u>		LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 HARFORD MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) <u>Miles Olney Howell</u>				<u>MARCH 22</u> 19 <u>55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8/11/1902</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Int. Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lat. Mechanic</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>P. G. Howell</u>				14. MOTHER'S MAIDEN NAME <u>Adeline HARTM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-18-0546</u>		17. INFORMANT & ADDRESS <u>Mrs. Arbutus G. Howell, Joppa, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
6920 IMMEDIATE CAUSE (A) <u>Acute Staphylococcic Septicemia from</u>						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Staph. Cellulitis of face</u>						10 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Secondary Anemia --Nutritional origin ??</u>						??	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>March 15, 1955</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 15, 1955</u> , to <u>March 22, 1955</u> , that I last saw the deceased alive on <u>March 22, 1955</u> , and that death occurred at <u>12:17 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>		DATE SIGNED <u>3-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 25, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Grove,</u>		LOCATION (City, town, or county) (State) <u>Fountain Green, Harford, Md.</u>	
24. REC'D BY REGISTRAR <u>Mar. 25-55</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Howard K. McComas & Son, Abingdon, Md.,</u>			
				<u>Howard K. McComas</u>			

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BUREAU V. 3

MAR 28 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2742

CERTIFICATE OF DEATH

02724

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>		CITY <u>Havre de Grace</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		LENGTH OF STAY (in this place) <u>Nine hours</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		CITY <u>Indefinite</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U S Army Hospital</u> <u>Aberdeen Proving Ground Md</u>				STREET ADDRESS (If rural give location) <u>Pulaski Trailer Park</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Michael</u> <u>Leroy</u> <u>Johnson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar</u> <u>8</u> <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>20 Nov 1954</u>	9. AGE last birthday yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>18</u>	IF UNDER 24 HRS. Days <u>18</u> Hours <u>53</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Lewis Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Elaine Marie Jordan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>4 No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father Robert L Johnson</u> <u>Pulaski Trailer Pk Havre de Grace Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						9 hrs.	
IMMEDIATE CAUSE (A) <u>Sub-arachnoid hemorrhage spontaneous</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>arachnoid?</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7 March</u> , 19 <u>55</u> , to <u>8 March</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8 March</u> , 19 <u>55</u> , and that death occurred at <u>1.30a</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Richard Allen</u>				ADDRESS (Street, city, town, state) <u>US ARMY HOSP APG MD</u>			
M.D. RICHARD ALLEN Capt MC				DATE SIGNED <u>8 March 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>3-12-55</u>	NAME OF CEMETERY OR CREMATORY <u>Memorial Cemetery</u>		LOCATION (City, town, or county) <u>Oelwein Iowa</u>		(State)	
24. REC'D BY REGISTRAR DATE <u>March 9-1955</u>	REGISTRAR'S SIGNATURE <u>Hellie G. Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bennington + Son Havre de Grace, Md.</u>		ADDRESS		

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02725

2743

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Abingdon		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Abingdon		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last) Edward M. Lee				4. DATE OF DEATH (Month) (Day) (Year) March 15 19 55			
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH July, 1, 1879		9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Abingdon, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert E. Lee				14. MOTHER'S MAIDEN NAME Evelyn Hanson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-09-7402		17. INFORMANT & ADDRESS Bertha Lee, Abingdon, Maryland.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <u>Uremia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/27</u>, 19 <u>55</u>, to <u>3/15</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>3/14</u>, 19 <u>55</u>, and that death occurred at <u>8:30 p</u> M, from the causes and on the date stated above.							
SIGNATURE George J. Stanbury		ADDRESS (Street, city, town, etc.) M.D. 569 Revolution St. Havre de Grace, Md.		DATE SIGNED 3/19/55			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Mar. 19, 1955		NAME OF CEMETERY OR CREMATORY John Wesley		LOCATION (City, town, or county) (State) Abingdon, Harford, Md.	
24. REC'D BY REGISTRAR March 19, 1955		REGISTRAR'S SIGNATURE Norma S. Moore		25. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son			
				ADDRESS Abingdon, Md.			

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death	
John Doe		45		Male		White		Caucasian		Roman Catholic		Single		Teacher		Heart Disease		March 22, 1955		Baltimore, Md.	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Health Officer		Signature of Funeral Home		Signature of Burial Place		Signature of Cemetery		Signature of Undertaker		Signature of Mortician		Signature of Embalmer	

*Uremia
Contributed to that cause*

BUREAU V. S.

MAR 22 1955

RECEIVED

George J. Stenhouse

3/21 2 29p

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2730

CERTIFICATE OF DEATH

02726

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>DECI</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Harford de Grace</u>		LENGTH OF STAY (in this place) <u>13 hrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>North East MD 07x2</u>			
TOWN <u>Harford</u>				STREET ADDRESS (If rural give location) <u>WALLACE Ave.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Mem. Hosp.</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Robert</u> (Middle) <u>Charles</u> (Last) <u>Loynds</u>				<u>March 11</u> 19 <u>55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>9-20-1906</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aberdeen Prov. G</u>		11. BIRTHPLACE (State or foreign country) <u>Upland PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Loynds</u>				14. MOTHER'S MAIDEN NAME <u>LAURA Stille</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>179-07-0209</u>		17. INFORMANT & ADDRESS <u>Sarah E. Loynds, North East Md</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
162x IMMEDIATE CAUSE (A) <u>Bronchogenic Carcinoma</u>						<u>6 months</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 15, 1955</u> to <u>March 11, 1955</u> that I last saw the deceased alive on <u>11 March 1955</u> and that death occurred at <u>10:40 A.</u> M, from the causes and on the date stated above. SIGNATURE <u>E. J. Sumin</u> M. D. <u>Harrell Grace</u> DATE SIGNED <u>3-11-55</u> ADDRESS (Street, city, town, state) (State)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Lawncroft</u>		LOCATION (City, town, or county) (State) <u>Delaware Co., Pa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>		ADDRESS <u>North East, Md</u>	
DATE <u>Mar 15-55</u>							

CERTIFICATE OF DEATH

2750

Reg. Dist. No.

1. USUAL RESIDENCE (HOME OR ESTABLISHMENT)

MARYLAND

COUNTY OF

CITY OF

STREET

APARTMENT

ZIP CODE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF ANATOMY

PLACE OF ANATOMY

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REANATOMY

PLACE OF REANATOMY

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REANATOMY

PLACE OF REANATOMY

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REANATOMY

PLACE OF REANATOMY

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REANATOMY

PLACE OF REANATOMY

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

BUREAU V. S.

MAR 16 1955

RECEIVED

2001010101

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2731

CERTIFICATE OF DEATH

02727

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAURE de GRACE</u>		LENGTH OF STAY (in this place) <u>2 hrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harford de Grace</u>		<u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>324 Superior St - 1</u>			
3. NAME OF DECEASED (Type or Print) <u>Baby Girl</u> <u>ROSS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 7</u> <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>3-7-55</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Lawrence Ross</u>				14. MOTHER'S MAIDEN NAME <u>Edna Mabel Curry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>776x</u> IMMEDIATE CAUSE (A) <u>Permaternity</u>						<u>2 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/7, 1955</u> , to <u>3/7, 1955</u> , that I last saw the deceased alive on <u>3/7, 1955</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frederick D. Hatten</u> M.D.				ADDRESS (Street, city, town, state) <u>1774 White Blvd. Bel Air, Md.</u>		DATE SIGNED <u>3/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>3/9/55</u>		DATE THEREOF		NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Hospital</u>		LOCATION (City, town, of county) (State) <u>Haure de Grace, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Mar. 11-1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Zully</u>		ADDRESS <u>Administrator</u>	

2035295200

COMMISSION OF

2458

RECEIVED

MAR 16 1955

BUREAU V. S.

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2744

CERTIFICATE OF DEATH

02728

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL OR nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>Black Horse</i>	<i>nda</i>	TOWN <i>Black Horse</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<i>00</i>		<i>White Hall Rd.</i>	<i>1</i>
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>Mary Carl Saunders</i>		<i>Mar 26 1955</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>Female</i>	<i>col.</i>	<i>S.</i>	<i>Feb-16 1955</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
			<i>Haute de Groce</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Millard Saunders</i>		<i>Alma A. Jackson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT'S ADDRESS	
		<i>Alma A. Saunders White Hall Md</i>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
1751X IMMEDIATE CAUSE (A) <i>MENINGOCOCLE</i>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<i>0</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> et work et work	
22. I hereby certify that I attended the deceased from <i>6-4</i> , 19 <i>55</i> , to <i>3-26</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>3-26</i> , 19 <i>55</i> , and that death occurred at <i>6-4</i> A.M. from the causes and on the date stated above.			
SIGNATURE <i>Gerald C Palmer</i>		ADDRESS (Street, city, town, state) <i>Harford County Md.</i>	
DATE <i>3-30-55</i>		DATE SIGNED <i>3/26/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>Mt Joy</i>	
DATE THEREOF <i>3-28-55</i>		LOCATION (City, town, or county) <i>Harford Md.</i>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <i>Pussilla Lowwood</i>		<i>Martin E. Kutz</i>	
DATE <i>3-30-55</i>		ADDRESS <i>Franklinville Md</i>	

2025317404

CERTIFICATE OF DEATH

Hartford
Black Horse road

Hartford
Black Horse
White Hall Rd.

May	6971	24	Ward 25
Female	2	Feb-11 1907	0
—	—	Have de Green	W.C.
Millard	24	Ward 25	W.C.
—	—	Ward 25	W.C.
—	—	Ward 25	W.C.
—	—	Ward 25	W.C.

MENINGOCOCCE

BUREAU V. S.

APR 1 1907

RECEIVED

Bureau 2-28-07 Mt Joy

RECEIVED
Bureau 2-28-07 Mt Joy

TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2745

CERTIFICATE OF DEATH

02729

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Penna</i>		COUNTY <i>Luzerne</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Fallston</i>		<i>6 months</i>		TOWN <i>Pittston</i>		<i>75X-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>R.F.D.#2 Box 83</i>				STREET ADDRESS (If rural give location) <i>10 Rock St.</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) <i>Christopher Conrad Schultz</i>				<i>Mar. 6 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>Mar. 15 1895</i>	<i>59</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Carpenter</i>		<i>Construction</i>		<i>Penna.</i>		<i>U.S.</i>	
13. FATHER'S NAME <i>Christopher Schultz</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Swartz</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>		<i>195-90-8310</i>		<i>Betty Mair Fallston Md</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<i>150X IMMEDIATE CAUSE (A) PULMONARY OEDEMA</i>						<i>6 mos</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C) <i>ADENOCARCINOMA OF ESOPHAGUS WITH METASTASIS TO LIVER</i>						<i>ABOUT 2 YEAR</i>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>DEC. 14, 1953</i>				19b. MAJOR FINDINGS OF OPERATION <i>ADENOCARCINOMA OF ESOPHAGUS</i>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>AUGUST, 1954</i> , to <i>MARCH 6, 1955</i> , that I last saw the deceased alive on <i>MARCH 3, 1955</i> , and that death occurred at <i>8:20A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Philip W. Henman</i>				ADDRESS (Street, city, town, state) <i>M.D. 307 Hickory, BEL Air, Md</i>		DATE SIGNED <i>MARCH 6, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Mar 10-1955</i>		<i>Hughestown Lutheran</i>		<i>Pittston Pa. Luzerne</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>DATE 3-12-55</i>		<i>Prucilla Lowwood</i>		<i>W.A. Archer</i>		<i>Benson Md</i>	

02730

MARYLAND 2746

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Philadelp Rural</u> TOWN <u>Philadelp</u> HOSPITAL OR INSTITUTION <u>Walters Nursing Home</u> STREET ADDRESS <u>75X-3</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Penna</u> COUNTY <u>Phila</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Phila</u> TOWN <u>Phila</u> STREET ADDRESS (If rural, give location) <u>75X-3</u>	
3. NAME OF DECEASED (Type or Print) <u>George</u> (First) <u>Seitter</u> (Middle) <u>Seitter</u> (Last)		4. DATE OF DEATH <u>March 8</u> 19 <u>55</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, <u>Married</u> WIDOWED, DIVORCED	8. DATE OF BIRTH <u>March 13, 1873</u> 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Phila Penna U.S.A.</u>
13. FATHER'S NAME <u>Geo. F. Seitter</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Brings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs Charles Schlicht</u>		18. MEDICAL CERTIFICATION <u>Phila, Penna.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4221 Immediate cause (a) Arteriosclerotic C.V. disease Interval between onset and death 1 week

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March 1, 1955, to March 8, 1955, that I last saw the deceased

alive on March 8, 1955, and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Gerald C Palmer M.D. Bel Air Md. 3/8/55

23. BURIAL CREMATION DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Removal March 9, 1955 North Cedar Hill, Phila, Penna

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

March 10, 1955 C. W. Firk Charles Kester 609 East Allegheny Ave. Phila, Penna

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 16 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2732

CERTIFICATE OF DEATH

02731

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		STATE <u>Md.</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	
TOWN <u>Harford</u>		LENGTH OF STAY (In this place) <u>24 hrs</u>		TOWN <u>Harford</u>		TOWN <u>Harford</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS (If rural give location) <u>3030 S. Wash. St.</u>					
3. NAME OF DECEASED (Type or Print) <u>Agnes Louise Sparks</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3/14/55</u>			
S. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/13/53</u>	9. AGE last birthday <u>2</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u>24</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newborn</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Norman Sparks</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Walter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>Hospital records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
761.5 IMMEDIATE CAUSE (A) <u>RESPIRATORY FAILURE</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>EXTREME PREMATURITY</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>SEPARATION OF PLACENTA -</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>(BIRTH WEIGHT 2' 1/2")</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>13 MAR 55</u> , to <u>14 MAR 55</u> , that I last saw the deceased alive on <u>14 MAR 19 55</u> , and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. B. Neuman</u> M. D.				ADDRESS (Street, city, town, state) <u>Harford, Md.</u>		DATE SIGNED <u>3.14.55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		LOCATION (City, town, or county) (State) <u>Harford, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis m.d.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Flannery</u>		ADDRESS <u>Harford, Md.</u>	

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2747

CERTIFICATE OF DEATH

Reg. Dist. No.

02732
182

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL OR end give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Darlington</i>	<i>4 years</i>	TOWN <i>Darlington</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>John Avery Stainback</i>		<i>MARCH 7, 1955</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>Sept. 12, 1876</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	9b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)
<i>Retired Farmer</i>	<i>Potomac, Va</i>	<i>78</i> yrs.	
10a. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
<i>Potomac, Va</i>	<i>U.S.A</i>		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>Unknown</i>	<i>Unknown</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
<i>No</i>	<i>212-22-2508</i>	<i>John Cooley</i>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <i>794X</i>		<i>Darlington, Md.</i>	
ANTECEDENT CAUSE(S) DUE TO		<i>old age</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2</i>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>0</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>March</i>, 19<i>54</i>, to <i>March</i>, 19<i>55</i>, that I last saw the deceased alive on <i>March 6</i>, 19<i>55</i>, and that death occurred at <i>9 P</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Malcolm Muddy Phillips</i>		ADDRESS (Street, city, town, state) <i>Darlington Md</i>	
DATE THEREOF <i>March 10, 1953</i>		DATE SIGNED <i>3/11/55</i>	
NAME OF CEMETERY OR CREMATORY <i>Churchville</i>		LOCATION (City, town, or county) (State) <i>Harford Co, Md.</i>	
24. REG'D BY REGISTRAR <i>March 10, 1953</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>H.S. Bailey</i>	
REGISTRAR'S SIGNATURE <i>C. G. Kirby</i>		ADDRESS <i>Darlington Md</i>	

CERTIFICATE OF DEATH

2717

1. IN THE COUNTY OF ... STATE OF ...

2. DECEASED'S NAME ...

3. SEX ...

4. AGE ...

5. DATE OF DEATH ...

6. PLACE OF DEATH ...

7. CAUSE OF DEATH ...

8. MANNER OF DEATH ...

9. SIGNATURE OF ...

10. SIGNATURE OF ...

11. SIGNATURE OF ...

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BUREAU V. S.

MAR 16 1955

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VS A15C 1-55 10M

2733

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02733

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAVER DE GRACE</u>		<u>1/2 HR.</u>		TOWN <u>ABERDEEN</u>		<u>31</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location) <u>12 HANOVER</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>CECILIA</u> <u>SUMMERS</u>				<u>MARCH 26</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FEMALE</u>	<u>COLORED</u>	<u>DIVORCED</u>	<u>FEB. 8, 1909</u>	<u>46</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>DOMESTIC</u>		<u>Housekeeper</u>		<u>Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Cicero A. Summers</u>				14. MOTHER'S MAIDEN NAME <u>MARY X HARDY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>226-20-7650</u>		<u>CATHERINE SUMMER BROWN</u>			
18. MEDICAL CERTIFICATION				<u>RICHMOND, VA.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				<u>1 Hr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Hypertensive Cardiovascular disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec.</u> , 19 <u>54</u> , to <u>March 26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 24</u> , 19 <u>55</u> , and that death occurred at <u>2:52</u> M, from the causes and on the date stated above.							
SIGNATURE <u>George T. Stansbury, M.D.</u>				ADDRESS (Street, city, town, state) <u>569 Revolution St. Havre de Grace Md.</u>		DATE SIGNED <u>3/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Mar. 29 '55</u>		NAME OF CEMETERY OR CREMATORY <u>ST. JAMES</u>		LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>HAVRE DE GRACE MD.</u>	
DATE <u>Mar 28-1955</u>							

CERTIFICATE OF DEATH

6383

MD-210-552

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. AGE

6. DATE OF BIRTH

7. MONTH OF BIRTH

8. DAY OF BIRTH

9. YEAR OF BIRTH

10. MONTH OF DEATH

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114. YEAR OF DEATH

BUREAU V. S.

MAR 29 1955

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

2735

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02734

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Hartford</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Hartford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Laurel de Grace</i>		LENGTH OF STAY (In this place) <i>8 min.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Laurel de Grace</i>		<i>24</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Haynes Memorial</i>				STREET ADDRESS (If rural give location) <i>Pulaski Trailer Court</i>			
3. NAME OF DECEASED (Type or Print) <i>Baby Boy</i> (First) <i>Thompson</i> (Middle) (Last)				4. DATE OF DEATH (Month) <i>March</i> (Day) <i>5</i> (Year) <i>1955</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>3/5/55</i>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min. <i>8</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Walter Thompson</i>				14. MOTHER'S MAIDEN NAME <i>Clara Kent</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Hosp. Records</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
776X IMMEDIATE CAUSE (A) <i>Prematurity</i>						INTERVAL BETWEEN ONSET AND DEATH <i>8 min.</i>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/5</i> , 19 <i>55</i> , to <i>3/5</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>3/5</i> , 19 <i>55</i> , and that death occurred at <i>11:05 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Frederick J. Hutton</i> M.D.				ADDRESS (Street, city, town, state) <i>1701 Park Blvd. Annapolis, Md.</i>		DATE SIGNED <i>3/5/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3/6/55</i>		NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>		LOCATION (City, town, or county) (State) <i>Hartford Md.</i>	
24. REC'D BY REGISTRAR DATE <i>Mar 6 - 1955</i>		REGISTRAR'S SIGNATURE <i>G. L. Lewis M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick J. Hutton</i>		ADDRESS <i>Hartford Md.</i>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Harre de Grace</u>		LENGTH OF STAY (in this place) <u>2 hrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Perryman, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 HARFORD Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Dennis Leroy Warfield</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 13 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col</u>	7. <input checked="" type="checkbox"/> SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MARCH 13, 1955</u>	9. AGE last birthday <u>-</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Warfield</u>				14. MOTHER'S MAIDEN NAME <u>Katie Martha Christy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>g</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mother - Perryman Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>157-1</u> IMMEDIATE CAUSE (A) <u>Bilateral Congenital Kidney disease (Incompatible with Life)</u>							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2+</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>13 March, 1955</u> , to <u>13 March, 1955</u> , that I last saw the deceased alive on <u>13 March, 1955</u> , and that death occurred at <u>5:45 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>George J. Stansbury</u>				ADDRESS (Street, city, town, state) <u>M.D. 569 Revolution St, Harre de Grace, Md.</u>		DATE SIGNED <u>3/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>3/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Hospital</u>		LOCATION (City, town, or county) (State) <u>Harre de Grace, Md</u>	
24. REC'D BY REGISTRAR DATE <u>Mar. 15 - 1955</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R Tully</u>		ADDRESS <u>Administrator</u>	

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CERTIFICATE OF DEATH

1955

Reg. Dist. No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF DISTRICT ATTORNEY

19. SIGNATURE OF CLERK OF DISTRICT COURT

20. SIGNATURE OF CLERK OF SUPREME COURT

Attested (Gonorrhea) (with wife)

BUREAU V. L.

MAR 16 1955

RECEIVED

George J. Stankiewicz

NOTICE: This certificate is valid only if it is signed by the physician, registrar, witnesses, clerk, jury, judge, sheriff, coroner, district attorney, clerk of district court, and clerk of supreme court. If any of these signatures are missing, the certificate is invalid.